



Improving aged care homes through design





Improving aged care homes through design

Chair:

- Marianne Madden, a/g Assistant Secretary, Dementia, Diversity and Design Branch

Presenters:

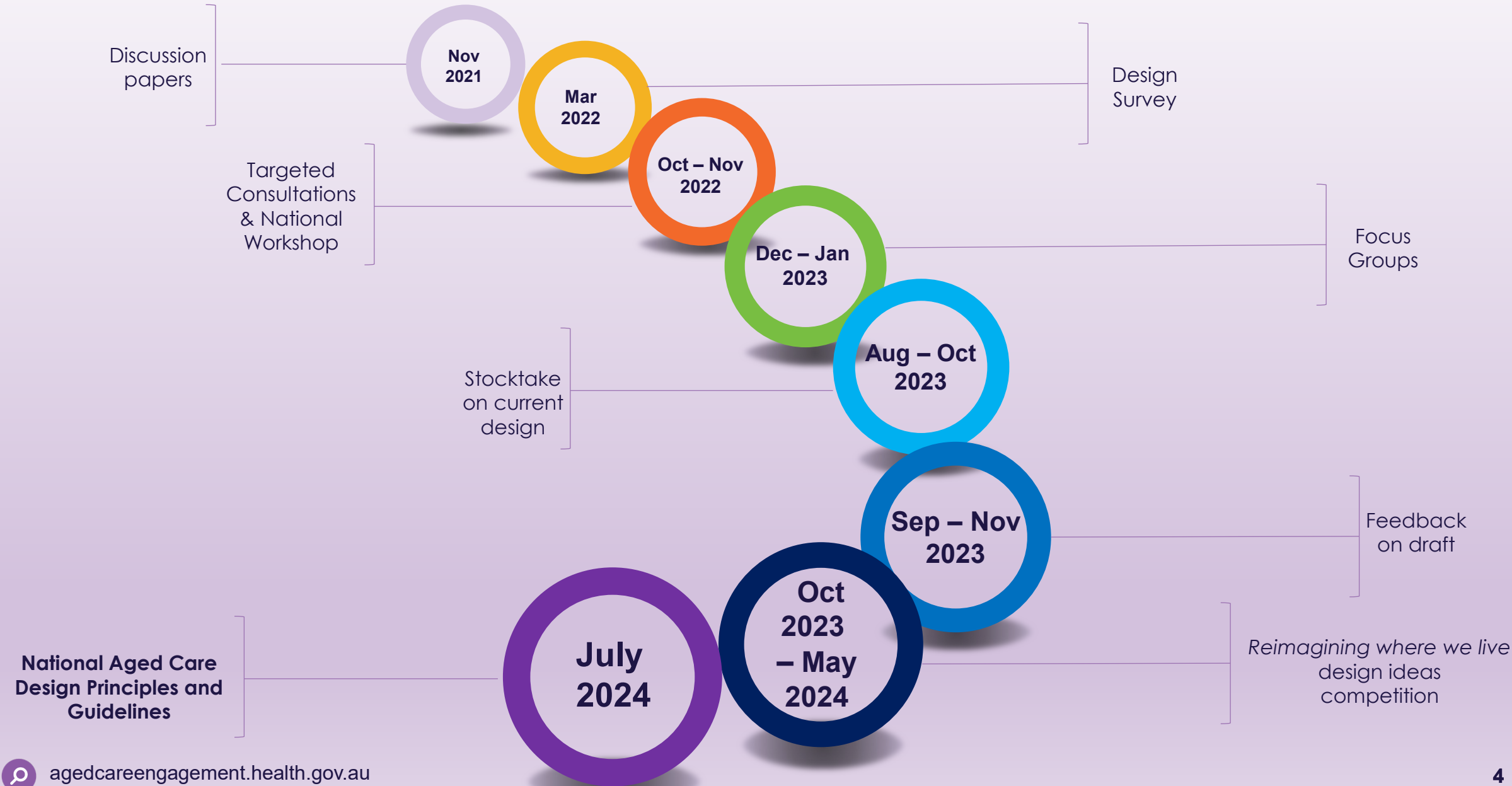
- Naomi Wilkins, Director, Design and Dementia Support Section
- Nick Seemann and Liz Fuggle, Constructive Dialogue Architects and Dementia Training Australia, lead authors of the National Aged Care Design Principles and Guidelines
- Angela Raguz, General Manager, Residential Care and Dementia Centre, HammondCare

Overview

- Older people need aged care accommodation that is:
 - well designed
 - accessible
 - dementia-friendly
- Recommendation 45 of the Royal Commission into Aged Care Quality and Safety
- *National Aged Care Design Principles and Guidelines* were introduced in July 2024



Consultation



National Aged Care Design Principles and Guidelines



Principles and Guidelines

- A consortium team led by the University of Wollongong helped develop the Principles and Guidelines
- The Principles and Guidelines have been designed to support the development of:
 - safe and comfortable environments that promote resident independence, function and enjoyment
 - safe workplaces in which staff can provide high quality personal and clinical care



Australian Government

Department of Health and Aged Care

Introduction to the National Aged Care Principles and Guidelines

and how they can help improve the lives of residents

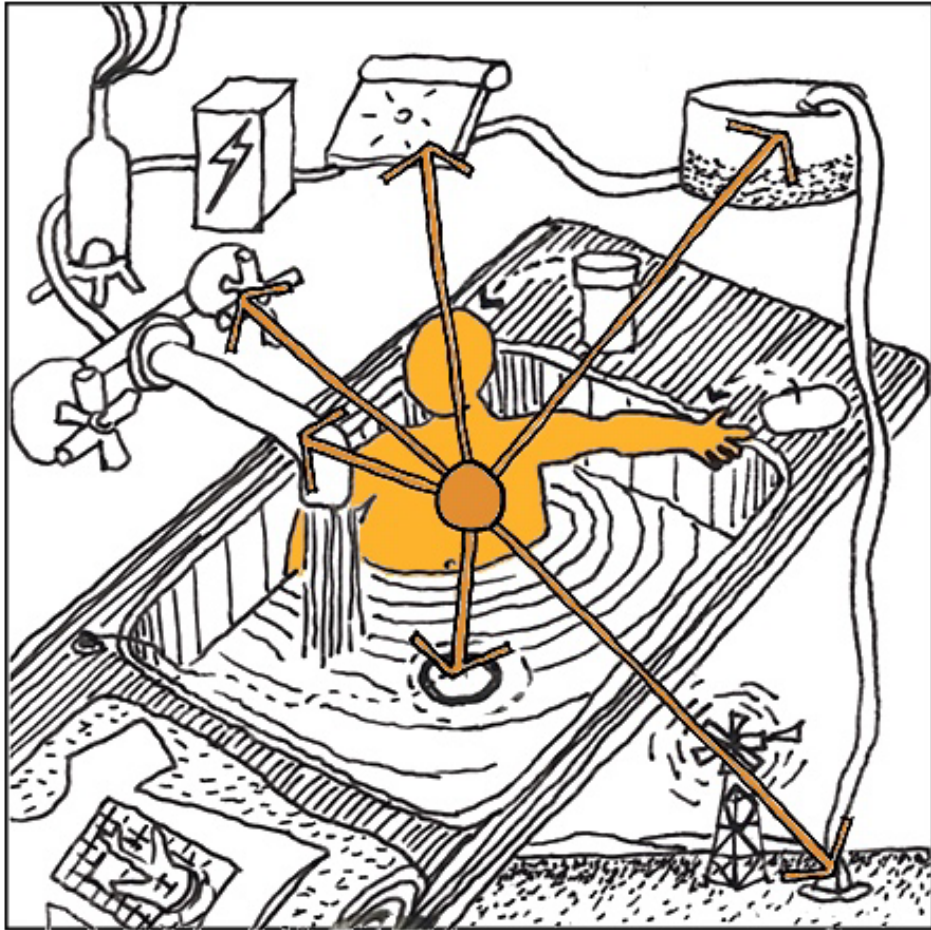
Nick Seemann and Liz Fuggle
Dementia Training Australia
Constructive Dialogue Architects





Housing for Health

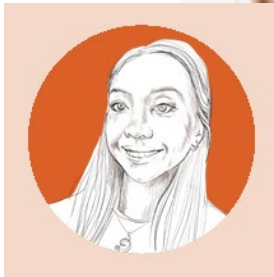
Health hardware linked to health outcomes



Paul Pholeros

Architect

www.housingforhealth.com



Guideline 2.4

Domestic Kitchens

An open plan domestic kitchen is at the heart of each household

Scenario

The opportunity to be with others and enjoy the stimulation of a positive dining experience is important for everyone. This experience is enhanced by the sights and smells of a domestic kitchen, and this is particularly helpful for people relying on reduced sensory capacity.



Anne often eats in her room. As she is not independently mobile it is difficult for her to be moved to the dining room and she doesn't want to trouble Eleesha who is already very busy. It feels to her that the food just arrives, and she finds it hard to taste and eat it. She often is surprised by what she is eating. She's beginning to have trouble swallowing which is frightening for her. She begins to dread mealtimes.



Eleesha assists Anne to eat in her room. She is concerned that Anne is losing weight.

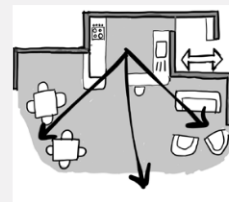
Rationale

Why is this important? Functional, domestic kitchens provide an anchor to environments often overwhelmed by clinical and operational apparatus. Kitchens can contribute to a domestic appearance, support activity meaningful to a resident,⁹⁶ maintain their connection with daily routines, and bolster independence.⁹⁷ Fully functioning domestic kitchens which engage residents are a stark contrast to institutional food preparation which reduce meals to a task.^{98,99} Kitchens provide a powerful landmark to orientation within a household.⁸⁰ Involvement of residents in sharing family-style meals,⁸¹ the preparation of meals, presence of food smells, and oversight of food preparation all contribute to nutritional outcomes.^{82,83} Central kitchens can also support the work of staff⁸⁴ and create a positive work environment for them to deliver person-centred care.⁸⁵ The ability to make or assist in making of meals, stimulates appetite.⁸⁶

What makes a difference? The key components of a successful kitchen are its presence, the adequacy of the fixtures to support cooking a meal, and the real and perceived access for residents and their families.^{87,88} Open layouts promote autonomy and food choice⁸⁹ and lower benches support accessibility to residents.⁹⁰ Whereas, closed kitchens, locked refrigerators, and the absence of cooking appliances negatively affect resident independence.⁹¹

Guideline

Provide a domestic-style kitchen that is accessible to people who live in a household and their visitors. The kitchen should be centrally located and adjacent to the dining area. The domestic kitchen might receive food from a commercial kitchen on or off site, or be the primary place of food preparation. Ideally, at least some preparation of meals occurs in this kitchen. The central location is key to safety as it supports visibility throughout the household and uses passive safety features.



There is a tension between safety concerns and allowing risk taking to support resident autonomy.⁹² However, it has been demonstrated that these risks can be successfully managed.

Checklist

- ① Provide a domestic, familiar kitchen in each household, open to communal areas
- ② Locate the kitchen next to a dining room, with a view of living areas and corridors
- ③ Stock the kitchen with crockery, appliances, and food items, at least as well as a staff kitchen
- ④ Provide common appliances, such as an oven, fridge, stove top, microwave, toaster, and kettle that are familiar and easy to use
- ⑤ Provide some open shelving or glass fronted cupboards to provide a view of food or crockery
- ⑥ Position a concealed staff area next to the kitchen for bulk food, equipment, medication, IT, and fire extinguishers
- ⑦ Include passive safety features such as a lockable knife drawer, induction stove top
- ⑧ Design of kitchens (and all rooms) must eliminate risks of entrapment

Outcomes



A domestic kitchen was installed next to the dining room. Eleesha has been encouraged to bring Anne (in her comfort chair) into the dining room for lunch. Anne can see what's happening in the kitchen. Eleesha is serving the food out onto plates and Anne is helping her getting ketchup from the fridge. It smells like fish and chips.

Anne wonders whether it's Friday today. They'd always have fish and chips at home on a Friday. Her lunch has mashed potato, but it's delicious. Anne sits with her and Eleesha at the table and chats about the red snapper and shrimp they used to have on the Amalfi coast.

The Principles and Guidelines at a Glance

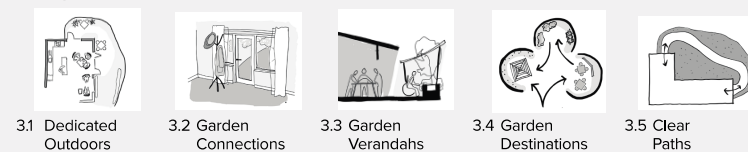
Principle 1 Enable the Person



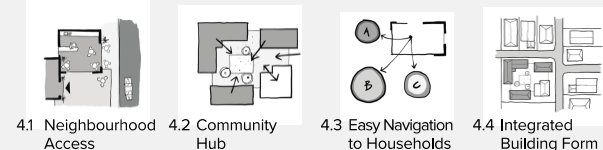
Principle 2 Cultivate a Home



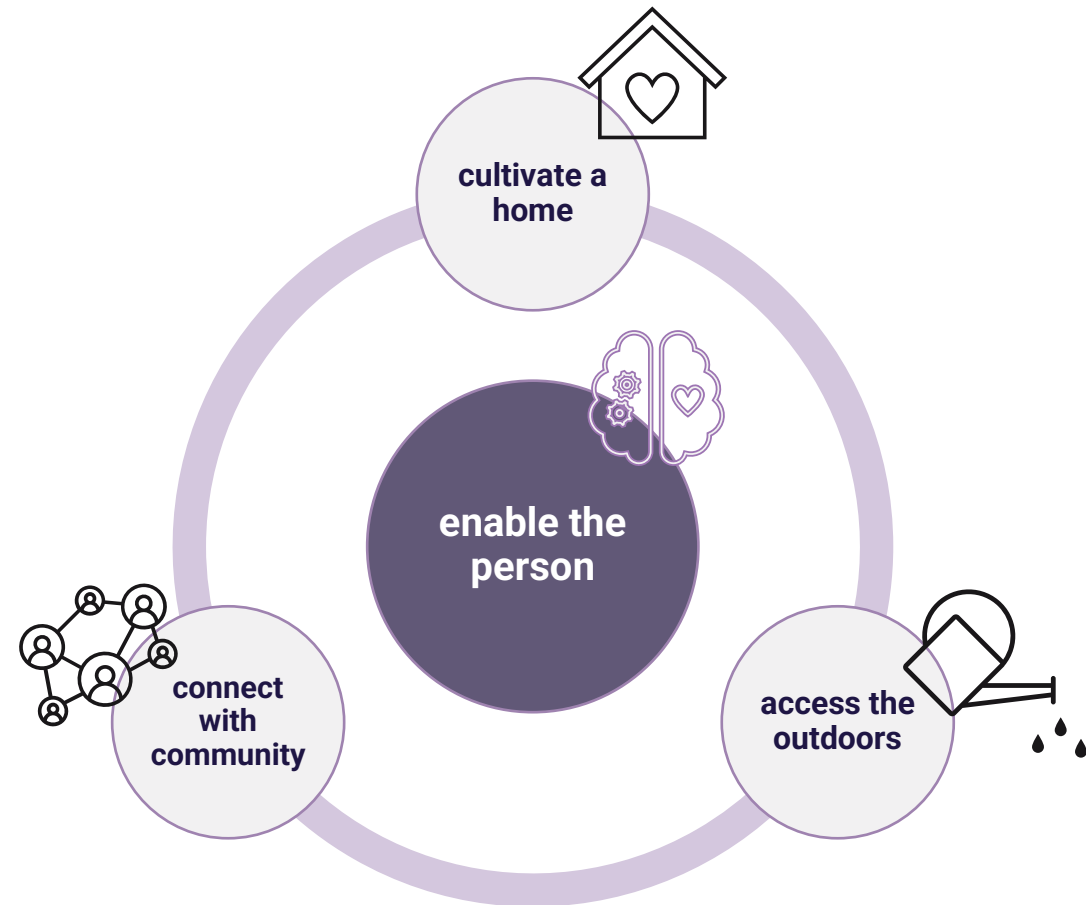
Principle 3 Access the Outdoors



Principle 4 Connect with Community



Four Principles 31 Guidelines



Principle 1 Enable the Person

To support people living
in a place that maintains
their health, wellbeing
and sense of identity



Principle 1 **Enable the Person**

To support people living
in a place that maintains
their health, wellbeing
and sense of identity





Principle 2 Cultivate a Home

To create a familiar environment in which people have privacy, control and feel they belong



Principle 3 Access the Outdoors

To support people seeing, accessing
and spending time outdoors in
contact with nature



Principle 1
Enable the Person

Principle 2
Cultivate a Home

Principle 3
Access the Outdoors

Principle 4
Connect with Community

*‘Good design makes things **possible**,
but it does not make things happen.’*

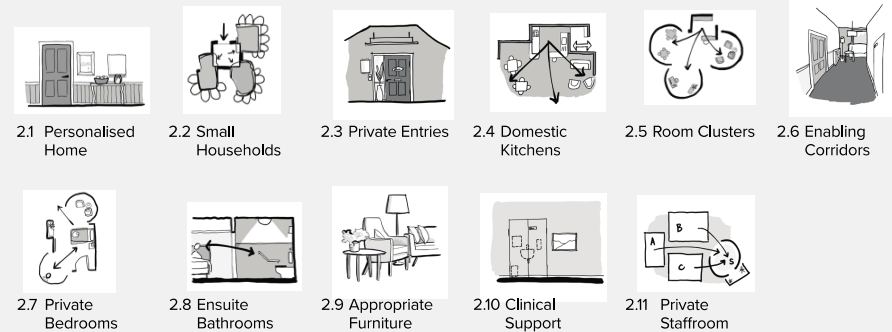
Professor Mary Marshall

The Principles and Guidelines at a Glance

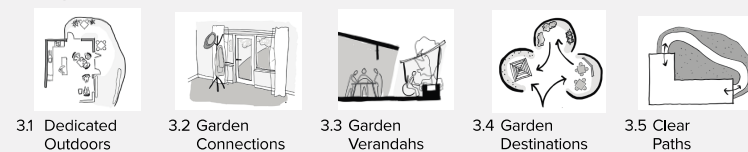
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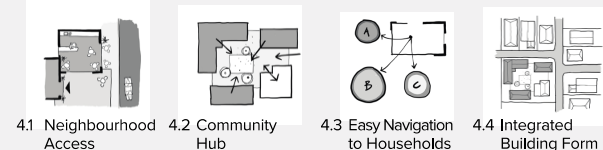
Principle 2 Cultivate a Home



Principle 3 Access the Outdoors



Principle 4 Connect with Community



Improving Buildings and Training Staff





What does good design in aged care look like?

Angela Raguz
HammondCare



Just good design

What does it look like?



Innovative features

What does it look like?



Small house model

Why use it?

Received: 16 August 2018 | Revised: 11 April 2019 | Accepted: 19 April 2019
DOI: 10.1111/ajag.12674

RESEARCH

Alternative staffing structures in a clustered domestic model of residential aged care in Australia

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Evidence behind The Green House and similar models of nursing home care

Sheryl Zimmerman¹ & Lauren W Cohen²

The Green House and similar models of nursing home care offer a solution to the nature of nursing homes. In The Green House model, small houses are home to a nurse who is given as much attention as treatment and is provided by a consistent team of staff who are responsible for all care, including preparing meals in a central kitchen. Residents have private rooms and bathrooms that open onto a central living area. A nurse is available 24 h a day and the clinical care team is nearby and visits the residents. The sense is that one is receiving care in a family-type setting. While expanding rapidly and seem to embody a better culture of nursing home care, they may depend on the evidence that supports or refutes the quality of care that they provide.

At any given time, 1.5 million individuals reside in nursing homes (NHs). Unfortunately, for most of these individuals, the NH is a setting of last resort because despite the care provided there and the improvements that have been witnessed in recent years, their ambience is essentially one of an institution (1). Fortunately, the future is not grim in this regard. A most promising development in NH care is encapsulated by the culture change movement, which seeks to change the organisational culture of NHs while attending to residents' healthcare needs. The best known example of NH culture change is the Eden Alternative, which encouraged companionship with children, adults and pets, promoted meaningfulness and control, and recast medical treatment as secondary to caring (2). However, the limitation of this and many other models of culture change is that they do not provide private rooms and bathroom central living area, and they impairments seen in traditional nursing homes, and although 24 h a day and the clinical and visits as needed, the sense in a home receiving care is missing (3). The Green House is a model that can be used only a license to do so. Viscerally, these settings better culture of NH care, a studies conducted to date (4) (mental design in four Greek two comparison sites) focus quality of life in four of 11 dignity, autonomy and for decline in late loss ADLs.

People living in residential aged care need to be outside not just SEE outside: associations between quality of life and outdoor access: a cross-sectional study

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Research article

Keywords: nursing homes, cognitive impairment, built environment

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Clinical Interventions in Aging
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REVIEW

Effects of person-centered care on residents and staff in aged-care facilities: a systematic review

Sonya Brownie
Susan Nancarrow
School of Health and Human Sciences
Southern Cross University, Lismore

International Journal of Nursing Studies
Volume 53, January 2016, Pages 238-247

The effects of the Green House nursing model on ADL function trajectory: A prospective longitudinal study

Roger L. Brown¹, Barbara J. Bowers², Siobhan S. Sharkey³

Empowering Direct Care Workers: Lessons Learned from THE GREEN HOUSE® Model

Barbara Bowers, PhD, RN; Kim Nolet, MS

ABSTRACT

The nursing home culture change movement continues to gain support from government, industry, and consumer groups. Many believe it holds promise for improving both the quality of care and the quality of life for people residing in long-term care settings. One of the challenges currently facing the movement is insufficient guidance regarding the specifics of both implementing and sustaining culture change. This article presents findings from a study of THE GREEN HOUSE® model, focusing specifically on the development of empowered direct care staff. Although the study was conducted exclusively in Green House homes, the findings have implications for any long-term care organization interested in empowering staff.

Research

Clustered domestic residential aged care in Australia: fewer hospitalisations and better quality of life

Suzanne M Dyer^{1,2}, Enwu Liu^{1,3}, Emmanuel S Gnanamanickam^{1,2}, Rachel Mitte^{1,4}, Tiffany Easton^{1,2}, Stephanie L Harrison^{1,2}, Clare E Bradley^{1,5}, Julie Ratcliffe^{2,4}, Maria Crotty^{1,2}

Abstract

Objective: To compare the outcomes and costs of clustered domestic and standard Australian models of residential aged care.

Design: Cross-sectional retrospective analysis of linked health service data, January 2015 – February 2016.

Setting: 17 aged care facilities in four Australian states providing clustered (four) or standard Australian (13) models of residential aged care.

Participants: People with or without cognitive impairment residing in a residential aged care facility (RACF) for at least 12 months, not in palliative care, with a family member willing to participate on their behalf if required. 901 residents were eligible; 541 consented to participation (24% self-consent, 76% proxy consent).

Main outcome measures: Quality of life (measured with EQ-5D-5L); medical service use; health and residential care costs.

Results: After adjusting for patient- and facility-level factors, individuals residing in clustered models of care had better quality of life (adjusted mean EQ-5D-5L score difference, 0.107; 95% CI, 0.028–0.186; $P = 0.006$), lower hospitalisation rates (adjusted rate ratio, 0.32; 95% CI, 0.13–0.79; $P = 0.010$), and lower emergency department presentation rates (adjusted rate ratio, 0.27; 95% CI, 0.14–0.53; $P < 0.001$) than residents of standard care facilities. Unadjusted facility running costs were similar for the two models, but, after adjusting for resident- and facility-related factors, it was estimated that overall there is a saving of \$12 962 (2016 values; 95% CI, \$11 092–14 831) per person per year in residential care costs.

Conclusions: Clustered domestic models of residential care are associated with better quality of life and fewer hospitalisations for residents, without increasing whole of system costs.

Methods

clustered domestic model of care and compared them with those for standard Australian models of residential aged care.

Small house model

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WILEY Australian Journal on Ageing

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People living in residential aged care need to BE outside not just SEE outside: associations between quality of life and outdoor access: a cross-sectional study



Empowering Direct Care Workers: Lessons Learned from THE GREEN HOUSE® Model

Clinical Interventions in Aging

Open Access Full Text Article

Effects of person-centered care on residents and staff in aged-care facilities: a systematic review

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The effects of the Green House nursing home model on ADL function trajectory: A retrospective longitudinal study

Ju Young Yoon^a, Roger L. Brown^{b,1}, Barbara J. Bowers^{c,2}, Siobhan S. Sharkey^d, Susan D. Horn^{e,3}

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Clustered domestic residential aged care in Australia: fewer hospitalisations and better quality of life

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Models for providing residential care are changing the world, with increasing emphasis on care in home-like environments. Large residential aged care facilities are still in Australia.

A clustered, domestic model of residential aged care associated with fewer hospitalisations and emergency department presentations and higher quality of life for residents, without increasing whole of system costs.

Smaller scale, clustered domestic models of care meet the preferences of residents and their improve health and quality of life outcomes at similar or lower costs.

Residential aged care facilities in Australia government about estimated that half the residents ensuring that these vulnerable is complex. The aged care ongoing reform to ensure that residents.

Australian cities had more the average facility size is also recognised that the well-

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Methods

01 Increased quality of life for residents

02 Increased quality of care for residents

03 Reduced likelihood of presenting to emergency

04 Reduced likelihood of hospitalisation

05 Reduced likelihood of receiving potentially inappropriate medication

Using the principles

How to make it work in aged care?

Before



After



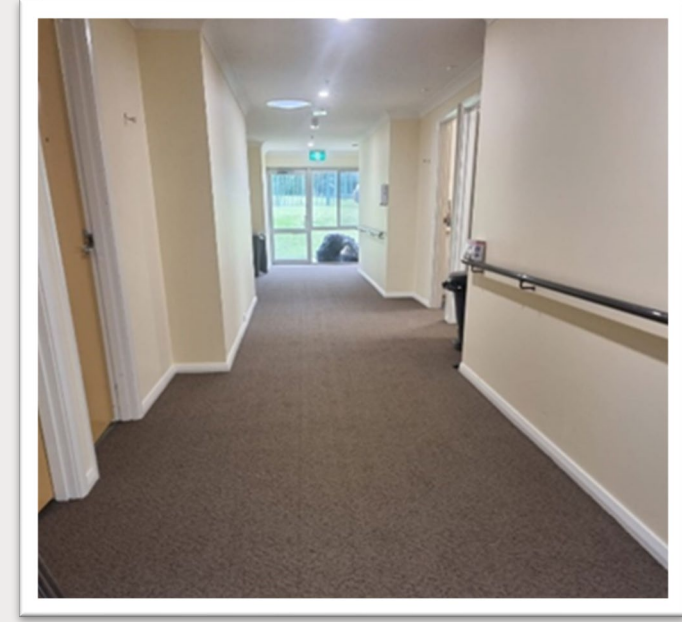
Using the principles

How to make it work in aged care?

Before



After



HammondCare

Champion Life



You can refer to DSA free. 24/7. Everyday. Anywhere.



Call us:
1800 699 799



Email us:
dsa@dementia.com.au



Visit us:
www.dementia.com.au



Live chat
accessible via the website

What do residential aged care providers need to do?

- The Principles and Guidelines are being introduced on a voluntary basis
- They include design features ranging from simple, low-cost changes through to more substantial features
- We will monitor their adoption to help inform long-term arrangements



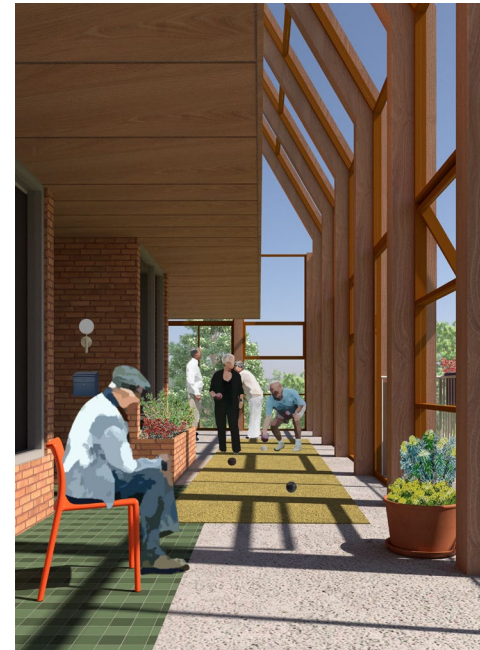
What support is there?

- Factsheets and publications on the Principles and Guidelines
- An environmental assessment tool
- The Aged Care Capital Assistance Program (ACCAP)



Reimagining where we live design ideas competition

- The design ideas competition tested and promoted awareness of the draft Principles and Guidelines and showcased what can be achieved through their application



Urban metro second place -
Connection, Community and
Movement



Regional town first place – Manu Place



Urban metro first place – Scales of Care

Resources

- You can find the following resources at www.health.gov.au using the search term *improving accommodation in residential aged care*:
 - National Aged Care Design Principles and Guidelines
 - Executive Summary of the Principles and Guidelines
 - Factsheet for older people, their families and carers
 - Factsheet for providers and staff
 - Factsheet for architects and designers



Questions?

- Please use the Q&A function to submit your questions
- We will answer the pre-submitted questions





Webinar survey

Thank you for attending today's webinar.

Please provide your feedback by answering 3 short questions.





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